

Electronic Billing Certification Form
Physician Services Contract Back (PSCB) and
Emergency Medical Services Appropriation (EMSA)
Contract Back Programs

Group MediCal No.: _____

Group Name: _____

Physician's Name: _____ Provider No.: _____

Affidavit of Physician or Physician's Representative

This is to certify that the information contained on these PSCB/EMSA Claims and data disk to be true, accurate, and complete. The physician/physician's group has read, understands and agrees to be bound by and comply with the policies, conditions and statements contained in the PSCB/EMSA Policies and Procedures Manual, related statutes and regulations and the Annual Physician Enrollment and Claim Certification. I further agree to cease all current and any future collection efforts when I receive any level of reimbursement of these claims from the PSCB/EMSA Contract Back programs.

By submitting and signing this certification form, I, as the attending physician or authorized certified representative, also hereby certify that on the third billing attempt, a copy of the "Notice of Privacy Practices" for the PSCB/EMSA Contract Back programs was sent and/or provided to all patients named on this electronic billing disk being submitted as required by the PSCB/EMSA Contract Back programs.

Total Claims Submitted: _____

Total Amount Claimed: \$ _____

☐ A Copy of the "Notice of Privacy Practices" was sent to all patients listed on this data disk being submitted.

Date

Authorized Representative's Signature